

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1865

9531

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
c. LENGTH OF STAY IN TB <u>-</u>		d. STREET ADDRESS <u>R.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>J.</u> Middle <u>A</u> Last <u>Abraham</u>		4. DATE OF DEATH <u>September 10 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1877</u>
9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis W. Abrahams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bartlett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John J. Abrahams Jr.</u>		Address <u>Port Deposit, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-8 1957</u> Hour <u>2</u> a. m. <u>9</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Port Deposit</u> (County) <u>Cecil</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>9-13-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		22d. LOCATION (City, town, or county) <u>Port Deposit, Md. Rural</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>G. L. Harris</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Harris</u>	
DATE <u>9-14-57</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09537

Reg. Dist. No. 182

9533

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Md</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRIDERICK A BENNINGTON</u>		4. DATE OF DEATH Month Day Year <u>9-21 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fortman of Bel Air Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Street Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>FRIDERIC E BENNINGTON</u>		14. MOTHER'S MAIDEN NAME <u>FLORANCE TARBERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>401-101-1011</u>	
17. INFORMANT <u>Mrs Margaret L Bennington</u> <u>106 W Main St Bel Air Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY OF CHEST & ABDOMEN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABDOMEN</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently run over by AUTO</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-1 9-21 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PARKING LOT</u>		20f. (City or town) (County) (State) <u>Bel Air HARTFORD MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 24, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR HARTF. CO., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fisher</u> <u>West Broadway</u> <u>BEL AIR, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 9-21-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Annella Lowndes</u>			

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH

SIGNATURE OF MEDICAL EXAMINER
DATE

LOCALITY
COUNTY

STATE

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S EDUCATION

DECEASED'S RELIGION

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH TIME

DECEASED'S BIRTH WEIGHT

DECEASED'S BIRTH LENGTH

DECEASED'S BIRTH HEAD CIRCUMFERENCE

DECEASED'S BIRTH SKIN COLOR

DECEASED'S BIRTH HAIR COLOR

BUREAU V. 5

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 20b Film 220 9-13-57 ams									
9560									
CERTIFICATE OF DEATH									
Reg. Dist. No. 181									
1. PLACE OF DEATH a. COUNTY Aberdeen Proving Ground b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford c. LENGTH OF STAY IN 1b 11 mos d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Hq & Hq Det OTC b. COUNTY Aberdeen Prov Grd Harfor c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Prov Grd, X2 d. STREET ADDRESS Aberdeen Prov Grd, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jerome A. BRADY					4. DATE OF DEATH Month Sept Day 1 Year 1957				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 August 1937		9. AGE (In years last birthday) 20 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? US Citizen	
13. FATHER'S NAME Mr. Edward Brady					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) 6/20/56 to dat					16. SOCIAL SECURITY NO. 288-30-9455		17. INFORMANT Pfc. Richard Maye Address Hq & Hq Det OTC APG Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inttra-cerebral hemorrhage & trauma 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound, inttra-cranial DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Circumstances unknown at this time/ Suicide				
20c. TIME OF INJURY Hour a. m. unknown Month, Day, Year Sep 1 1957			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barracks 5432		20f. (City or town) Aberdeen Proving Ground, Md. (County) (State)		
21. I certify that I attended the deceased from 1300 1 Sep , 19 57 , to 1450 1 Sep , 19 57 , that I last saw the deceased alive on 1450 1 Sep , 19 57 , and that death occurred at 2:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles C Weise M.D. U.S. ARMY HOSPITAL APG MD 1 September 57 PHYSICIAN'S NAME (Type) Charles C. Weise, Capt, MC									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/3/57		22c. NAME OF CEMETERY OR CREMATORY _____			22d. LOCATION (City, town, or county) Cleveland, Ohio (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John H. [unclear]				ADDRESS Aberdeen Md.		24a. REC'D BY REGISTRAR Sept 4-57		24b. REGISTRAR'S SIGNATURE Nellie G Perry	

BUREAU V. S.

RECEIVED

SEP 6 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9534 CERTIFICATE OF DEATH

09539

Reg. Dist. No. 1835

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARDE-GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CONOWINGO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>07 x 0.2</u>	
3. NAME OF DECEASED (Type or print) <u>Baby girl Brammer (Twin A)</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-57</u>
9. AGE (In years last birthday) <u>Newborn</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>md.</u>	
13. FATHER'S NAME <u>Clyde Brammer Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Suzanne Cather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Clyde Brammer Jr.</u>	
17. INFORMANT <u>Clyde Brammer Jr.</u>		Address <u>Conowingo Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia - 2nd 2 1/2 hrs. Baby</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-25</u> , 19 <u>57</u> , to <u>9-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>57</u> , and that death occurred at <u>2:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. H. Richards Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Port Deposit - Md. 9-26-57</u>	
PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>		<u>Port Deposit - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>9-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARTFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>HARDE DE GRACE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully</u>		ADDRESS <u>Administrator Hospital</u>	
24a. REC'D BY REGISTRAR DATE <u>10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis mal.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09540

9535

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Trin R) Baby Girl Brammer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25, 1957</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clyde Brammer</u>		14. MOTHER'S MAIDEN NAME <u>Susanne Cather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clyde Brammer</u>		Address <u>Conowingo, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary At. Infarctosis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pre-existing disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 25</u> , 1957, to <u>Sept 26</u> , 1957, that I last saw the deceased alive on <u>Sept. 26</u> , 1957, and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Port Deposit, Md.</u>		DATE SIGNED <u>9-27-57</u>	
PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>		ADDRESS (Street, city or town, state) <u>Port Deposit - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HARTFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully</u>		ADDRESS <u>Administrator - Hospital</u>	
24a. REC'D BY REGISTRAR <u>DATE 10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
DATE OF INTERMENT		PLACE OF INTERMENT		HOURS OF INTERMENT		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF INTERMENT		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	

BUREAU V. 2

OCT 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0954185**

1. PLACE OF DEATH a. COUNTY Harford 9536 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrods Grace -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville 07x2.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Harford Memorial Hosp		d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William James		4. DATE OF DEATH Month September Day 1 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 07 Days 22	IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician, Estimator, U.S.N. Hospital.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Amos M. Burlin		14. MOTHER'S MAIDEN NAME Eva M. McDonald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-03-7072	
17. INFORMANT Frances Burlin		Address Perryville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald E Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald E. Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md.	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-1-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-1957	
22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE 9-3-57		24b. REGISTRAR'S SIGNATURE Dr. D. L. Lewis	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the use of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

NEW YORK STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

SEP 5 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09542

9537 CERTIFICATE OF DEATH

Reg. Dist. No. 182.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>Md</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
CITY OR TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>4 mos 23 days</u>		STREET ADDRESS <u>108 SO BOND</u>		STREET ADDRESS (If rural give location) <u>108 SO BOND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 SO BOND</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SUSAN BLAIR CAMPBELL</u>				<u>SEPT 2 19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>FEMALE</u>	<u>W</u>	<u>SINGLE</u>	<u>APRIL 8, 1957</u>	<u>4</u>	<u>25</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>MARYLAND</u>		<u>USA.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES BURTON CAMPBELL</u>				<u>MILDRED ESTELLE DUFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>—</u>		<u>MOTHER BEL AIR, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
754.4 IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGENITAL HEART</u>						<u>1 DAY</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>SINCE BIRTH</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>4-9-57</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG 31</u>, 19<u>57</u>, to <u>SEPT 2</u>, 19<u>57</u>, that I last saw the deceased alive on <u>SEPT 2</u>, 19<u>57</u>, and that death occurred at <u>2:25 P.</u>M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Philip W Neuman</u>				<u>SEPT 2, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>BURIAL</u>				<u>9-3-57</u>			
DATE THEREOF				REGISTRAR'S SIGNATURE			
<u>Sept 3/57</u>				<u>Priscilla Lowndes</u>			
NAME OF CEMETERY OR CREMATORY				25. FUNERAL DIRECTOR'S SIGNATURE			
<u>BEL AIR MEMORIAL GARDENS BEL AIR MD</u>				<u>Joseph J Foster</u>			
LOCATION (City, town, or county) (State)				ADDRESS			
<u>BEL AIR MD</u>				<u>Bel Air Md</u>			

2047372XV5

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF REGISTRAR

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF INTERMENT

18. NAME OF INTERMENT PLACE

19. ADDRESS OF INTERMENT PLACE

20. CITY AND STATE OF INTERMENT PLACE

21. COUNTY OF INTERMENT PLACE

22. ZIP CODE OF INTERMENT PLACE

23. TELEPHONE NUMBER OF INTERMENT PLACE

24. NAME OF FUNERAL HOME

25. ADDRESS OF FUNERAL HOME

26. CITY AND STATE OF FUNERAL HOME

27. COUNTY OF FUNERAL HOME

28. ZIP CODE OF FUNERAL HOME

29. TELEPHONE NUMBER OF FUNERAL HOME

30. NAME OF BURIAL PLACE

31. ADDRESS OF BURIAL PLACE

32. CITY AND STATE OF BURIAL PLACE

33. COUNTY OF BURIAL PLACE

34. ZIP CODE OF BURIAL PLACE

35. TELEPHONE NUMBER OF BURIAL PLACE

36. NAME OF CEMETERY

37. ADDRESS OF CEMETERY

38. CITY AND STATE OF CEMETERY

39. COUNTY OF CEMETERY

40. ZIP CODE OF CEMETERY

41. TELEPHONE NUMBER OF CEMETERY

42. NAME OF FUNERAL HOME

43. ADDRESS OF FUNERAL HOME

44. CITY AND STATE OF FUNERAL HOME

45. COUNTY OF FUNERAL HOME

46. ZIP CODE OF FUNERAL HOME

47. TELEPHONE NUMBER OF FUNERAL HOME

48. NAME OF BURIAL PLACE

49. ADDRESS OF BURIAL PLACE

50. CITY AND STATE OF BURIAL PLACE

51. COUNTY OF BURIAL PLACE

52. ZIP CODE OF BURIAL PLACE

53. TELEPHONE NUMBER OF BURIAL PLACE

54. NAME OF CEMETERY

55. ADDRESS OF CEMETERY

56. CITY AND STATE OF CEMETERY

57. COUNTY OF CEMETERY

58. ZIP CODE OF CEMETERY

59. TELEPHONE NUMBER OF CEMETERY

60. NAME OF FUNERAL HOME

61. ADDRESS OF FUNERAL HOME

62. CITY AND STATE OF FUNERAL HOME

63. COUNTY OF FUNERAL HOME

64. ZIP CODE OF FUNERAL HOME

65. TELEPHONE NUMBER OF FUNERAL HOME

66. NAME OF BURIAL PLACE

67. ADDRESS OF BURIAL PLACE

68. CITY AND STATE OF BURIAL PLACE

69. COUNTY OF BURIAL PLACE

70. ZIP CODE OF BURIAL PLACE

71. TELEPHONE NUMBER OF BURIAL PLACE

72. NAME OF CEMETERY

73. ADDRESS OF CEMETERY

74. CITY AND STATE OF CEMETERY

75. COUNTY OF CEMETERY

76. ZIP CODE OF CEMETERY

77. TELEPHONE NUMBER OF CEMETERY

78. NAME OF FUNERAL HOME

79. ADDRESS OF FUNERAL HOME

80. CITY AND STATE OF FUNERAL HOME

81. COUNTY OF FUNERAL HOME

82. ZIP CODE OF FUNERAL HOME

83. TELEPHONE NUMBER OF FUNERAL HOME

BUREAU V. 8

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9538

CERTIFICATE OF DEATH

09543

Reg. Dist. No.

186

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>x2 Street, MD</u>	
3. NAME OF DECEASED (Type or print) <u>Sallie C. CARR</u>		4. DATE OF DEATH <u>September 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>DUBLIN, Md.</u>	
13. FATHER'S NAME <u>CHARLES McCANN</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE HOPKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MYRON CARR, BELAIR, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe hypochromic anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-12-</u> , 19 <u>57</u> to <u>9-19-</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Sept 19 1957</u> , and that death occurred at <u>930 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>8 Law St Aberdeen, MD.</u>	
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>		DATE SIGNED <u>9-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		ADDRESS <u>Aberdeen, MD.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u>		22d. LOCATION (City, town, or county) (State) <u>STREET, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>9-23-57</u>	
ADDRESS <u>Delta, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis, M.D.</u>	

SEP 24 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09544/185
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 9539 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Har- de Grace</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>				d. STREET ADDRESS <u>19 + 3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Jacob Carroll</u>				4. DATE OF DEATH Month Day Year <u>September 17 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5-1-79</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>			
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address <u>Mary Carroll Bel Air Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture L. Femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>904.0</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in his yard</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-7</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Bel Air</u>		(County) <u>Harford</u>		(State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford County</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>md</u>		DATE SIGNED <u>9-17-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>					
22b. DATE THEREOF <u>Sept 19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Watters Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Croftown Harford Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Tinto Bel Air md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 23 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>R. L. Lowrey</u>				24c. REGISTRAR'S SIGNATURE <u>R. L. Lowrey</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

BUREAU V. S.

SEP 28 1957

RECEIVED

9561

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWOOD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWOOD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL				e. STREET ADDRESS ARMY CHEMICAL CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALVIN VIRGIL CLINE				4. DATE OF DEATH Month Day Year SEPTEMBER 4 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 July 1937	
9. AGE (In years lost birthday) yrs. 20		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY US ARMY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME SILAS VIRGIL CLINE			
14. MOTHER'S MAIDEN NAME KATHLEEN ATWOOD				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES			
16. SOCIAL SECURITY NO. 236-58-0287				17. INFORMANT Address OFFICIAL US ARMY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRAGE AND EDEMA 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) TRAUMA TO HEAD DUE TO (c) AUTOMOBILE ACCIDENT							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AUTOMOBILE WENT OVER EMBANKMENT				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTOMOBILE WENT OVER EMBANKMENT			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12:04 Sept 4 1957				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET	
20f. (City or town) STREET				20g. (County) STREET		20h. (State) STREET	
21. I certify that I attended the deceased from 4 Sept , 19 57 to 4 Sept , 19 57 , that I last saw the deceased alive on 19 , and that death occurred at 12:04 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED 4 Sept 1957							
ACTUAL SIGNATURE Harlan W. Hawkinson M.D.				PHYSICIAN'S NAME (Type) HARLAN W HAWKINSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE TIME OF 9/5/57		22c. NAME OF CEMETERY OR CREMATORY Mullens West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Sarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Sept 6-57	
24b. REGISTRAR'S SIGNATURE W. H. G. Perry							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9562

CERTIFICATE OF DEATH

09546

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads XI</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Fallston R. D.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Virginia Cochran</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>5th</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG 13 1932</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Stephen</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Robert Six Fallston md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPT, cemia, Acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABcess, RT. Upper THigh</u> DUE TO (c) <u>Hypertensive - ARTERIOSCLEROTIC HEART Dis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>7 DAYS</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>57</u> , and that death occurred at <u>251</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. James Thomson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Jarrettsville, Md</u> DATE SIGNED <u>9/6/57</u>	
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMSON, JR MD.</u>		<u>JARRETTSVILLE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept 9-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Hydes, Balto co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Smith Jarrettsville Md</u>		24a. REC'D BY REGISTRAR <u>9-9-57</u> 24b. REGISTRAR'S SIGNATURE <u>Priscilla Fourvork</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9540

CERTIFICATE OF DEATH

Reg. Dist. No.

0954785

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>30 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>Rt # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Coldiron</u> Middle Last				4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6 - 1943</u>		9. AGE (In years lost birthday) <u>13</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Grover Coldiron</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Grover Coldiron Bel Air Md. Rt # 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aortic aneurysm with</u> <u>022X</u> DUE TO <u>hemopericardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Syphilitic Aortitis</u> DUE TO (c) <u>Congenital Syphilis</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hrs.</u> <u>Congenital</u> <u>Congenital</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac decompensation, Congenital hypoplasia - left kidney</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 13th</u> 19 <u>57</u> to <u>Sept. 14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 14th</u> 19 <u>57</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Bel Air, Md.</u> DATE SIGNED <u>9/15/57</u>							
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 17/57</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Fintor</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. L. Lewis</u>	

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9541

CERTIFICATE OF DEATH

09548

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE	c. LENGTH OF STAY IN b 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. STREET ADDRESS 141 OSBORNE Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary MAHARR First MAHARR Middle MAHARR Last COLE		4. DATE OF DEATH Month SEPT. Day 21 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas E. Kirby	
14. MOTHER'S MAIDEN NAME Mary Dugan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service) **	
16. SOCIAL SECURITY NO. None		17. INFORMANT Chas. A. Kirby, Aberdeen, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of head of pancreas DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ~ 2 mos. ~ 18 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 15 , 19 57 , to Sept 21 , 19 57 , that I last saw the deceased alive on Sept 20 , 19 57 , and that death occurred at 2:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B.J. Plunkett, Jr. M.D.		ADDRESS (Street, city or town, state) Aberdeen, Md. DATE SIGNED 9-21-57	
PHYSICIAN'S NAME (Type) B.J. Plunkett, Jr.		Aberdeen - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Parling ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE 9-24-57	24b. REGISTRAR'S SIGNATURE A. L. Davis M.D.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John J. Murphy		Male		65		10/15/1881		Boston, Mass.		Boston, Mass.		Heart Disease		10/25/1957		10:00 AM		Home		J. J. Murphy		J. J. Murphy	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Place		Signature of Minister		Signature of Registrar	
None		Married		High School		Catholic		None		Natural		St. Mary's Church		10/25/1957		10:00 AM		St. Mary's Church		J. J. Murphy		J. J. Murphy	

BUREAU V. 3

SEP 25 1957

RECEIVED

St. Mary's Cemetery
Aberdeen, Md.

B. J. Murphy, Jr.

10/25/57

John J. Murphy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09549
Reg. Dist. No. 180

9563

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Demby Town</u>				d. STREET ADDRESS <u>1 Demby Town</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALEXANDER</u> Middle <u>DEMBY</u> Last <u>DEMBY</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 26, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Mln. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer -</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Washington Demby</u>				14. MOTHER'S MAIDEN NAME <u>Maria Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Blanche Demby, Magnolia, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular</u> DUE TO <u>Disease with Hypertension</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Sept 19, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Magnolia, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCornick</u>				ADDRESS <u>Abingdon Md</u>		24a. REC'D BY REGISTRAR <u>Sept. 22, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: []
2. SEX: []
3. AGE: []
4. RACE: []
5. DATE OF BIRTH: []
6. PLACE OF BIRTH: []
7. OCCUPATION: []
8. CAUSE OF DEATH: []
9. MANNER OF DEATH: []
10. SIGNATURE OF EXAMINER: []
11. DATE OF EXAMINATION: []
12. PLACE OF EXAMINATION: []
13. SIGNATURE OF REGISTRAR: []
14. DATE OF REGISTRATION: []
15. PLACE OF REGISTRATION: []

BUREAU V. 5

SEP 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09550
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Forest Hill</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) <u>Cordelia</u> First <u>Edwards</u> Middle Last			4. DATE OF DEATH <u>September</u> Month <u>29</u> Day <u>19</u> Year <u>57</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17 1888</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Floyd Crouse</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Gambrell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>~</u>		
17. INFORMANT <u>Floyd Edwards</u> Address <u>Forest Hill md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns entire body</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House caught fire</u>			
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>9-24</u> p. m. <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Forest Hill</u> (County) <u>Harford</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. in</u> DATE SIGNED <u>9-25-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 27</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek</u>	22d. LOCATION (City, town, or county) <u>Chestnut Hill</u> (State) <u>md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Skurty</u>		ADDRESS <u>Jarrettville</u>		24a. REC'D BY REGISTRAR <u>9-30-57</u>	24b. REGISTRAR'S SIGNATURE <u>Prueella Lowwood</u>

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		BIRTHPLACE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS		TOXICOLOGICAL EXAMINATIONS		OTHER EXAMINATIONS	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE		HOSPITAL		CITY	

RECEIVED
OCT 2 1957
BUREAU V. S.

9542

CERTIFICATE OF DEATH

09551

Reg. Dist. No. 180

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace Md</u>	c. LENGTH OF STAY IN 1b <u>29 1/2 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Abingdon</u>	
d. NAME OF HOSPITAL (If not in-hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harrie</u>		4. DATE OF DEATH Month Day Year <u>Sept. 17 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1957</u>
9. AGE (In years lost birthday) <u>29</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Mildred R. Harrie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity -</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 16, 1957</u> to <u>Sept. 17, 1957</u> , that I last saw the deceased alive on <u>Sept 17, 1957</u> , and that death occurred at <u>145 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George J. Stansbury</u> M.D. <u>529 Revolution St, Harre de Grace, Md</u> <u>9/19/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> <u>HARRE de GRACE, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>9-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Casey</u> ADMINISTRATOR		24a. REC'D BY REGISTRAR DATE <u>9-27-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. R. Lewis M.D.</u>

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

SEP 30 1957

RECEIVED

9565

CERTIFICATE OF DEATH

09552/82
Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Norrisville		c. LENGTH OF STAY IN 1b 5yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7	
3. NAME OF DECEASED (Type or print) First David Middle Clarence Last Heaps		4. DATE OF DEATH Month Sept. Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 8, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David W. Heaps		14. MOTHER'S MAIDEN NAME Elizabeth King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Nannie Heaps, White Hall RD, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency due to 420.1 DUE TO heart failure, chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) + angina DUE TO (c) + angina			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 12, 1956 to Sept. 5, 1957 , that I last saw the deceased alive on Sept. 3, 1957 , and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman H. Gemmill M.D.		ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED Sept. 5, 1957	
PHYSICIAN'S NAME (Type) Norman H. Gemmill		Stewartstown, Penna.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9-8-57	Ayres Chapel Cem.	White Hall RD, Harford Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Crishen		ADDRESS Stewartstown, Penna.	24a. REC'D BY REGISTRAR DATE 9-7-57
		24b. REGISTRAR'S SIGNATURE Russella Lowmork	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

CERTIFICATE OF DEATH

09553
185

Reg. Dist. No.

9543

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BELCAMP, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILY N. HESOUN</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 23 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 16, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CYRIL STETKER</u>		14. MOTHER'S MAIDEN NAME <u>Josephina Kopecek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-18-6857</u>	
17. INFORMANT <u>JAMES HESOUN</u>		Address <u>BELCAMP, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 15th, 1957</u> , to <u>Sept. 22, 1957</u> , that I last saw the deceased alive on <u>Sept. 22nd, 1957</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Foo, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>211 North Union Ave. 9/23/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>		<u>Haure de Grace Ind</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McBratney</u>		ADDRESS <u>Abingdon, Md.</u>	
24a. RECEIVED BY REGISTRAR <u>SEP 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 8

SEP 26 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09554

9566

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 6 hrs 15 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3/ Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital			d. STREET ADDRESS Blue Bell Motel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Deborah Middle Sue Last Hill			4. DATE OF DEATH Month September Day 5 Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5, 1957		9. AGE (In years last birthday) yrs. 8 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Franklin Hill			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT Father Address (same as in 2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH -
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. 5 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aberdeen Proving Ground, Md	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 5 Sept , 19 57 , to 5 Sept , 19 57 , that I last saw the deceased alive on 5 Sept , 19 57 , and that death occurred at 1115 a.m. , from the causes and on the date stated above.					
ACTUAL SIGNATURE E W Watts Jr. Capt MC M.D.			ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED 5 Sept 1957		
PHYSICIAN'S NAME (Type) E W WATTS JR, Capt, MC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/1957		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	
22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md					
23. FUNERAL DIRECTOR'S SIGNATURE John H. Jennings			ADDRESS Aberdeen, Md		24a. REC'D BY REGISTRAR DATE Sept 6 - 57
			24b. REGISTRAR'S SIGNATURE Hellie R. Perry		

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RECEIVED

SEP 9 1957

BUREAU V. 2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CHURCH	
18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF INTERVIEWER	
20. SIGNATURE OF SUPERVISOR	
21. SIGNATURE OF ASSISTANT SUPERVISOR	
22. SIGNATURE OF CLERK	
23. SIGNATURE OF RECEPTIONIST	
24. SIGNATURE OF TELEPHONE OPERATOR	
25. SIGNATURE OF MAIL ROOM	
26. SIGNATURE OF RECORDS SECTION	
27. SIGNATURE OF IDENTIFICATION SECTION	
28. SIGNATURE OF LABORATORY	
29. SIGNATURE OF X-RAY DEPARTMENT	
30. SIGNATURE OF RADIOLOGY	
31. SIGNATURE OF PATHOLOGY	
32. SIGNATURE OF ANATOMY	
33. SIGNATURE OF HISTOLOGY	
34. SIGNATURE OF CYTOLOGY	
35. SIGNATURE OF MICROBIOLOGY	
36. SIGNATURE OF IMMUNOLOGY	
37. SIGNATURE OF EPIDEMIOLOGY	
38. SIGNATURE OF PUBLIC HEALTH	
39. SIGNATURE OF COMMUNITY HEALTH	
40. SIGNATURE OF SCHOOL HEALTH	
41. SIGNATURE OF OCCUPATIONAL HEALTH	
42. SIGNATURE OF ENVIRONMENTAL HEALTH	
43. SIGNATURE OF NUTRITION	
44. SIGNATURE OF PHYSICAL EDUCATION	
45. SIGNATURE OF RECREATION	
46. SIGNATURE OF ARTS AND CRAFTS	
47. SIGNATURE OF MUSIC	
48. SIGNATURE OF THEATRE	
49. SIGNATURE OF FILM	
50. SIGNATURE OF TELEVISION	
51. SIGNATURE OF RADIO	
52. SIGNATURE OF JOURNALISM	
53. SIGNATURE OF LITERATURE	
54. SIGNATURE OF SCIENCE	
55. SIGNATURE OF HISTORY	
56. SIGNATURE OF GEOGRAPHY	
57. SIGNATURE OF POLITICAL SCIENCE	
58. SIGNATURE OF ECONOMICS	
59. SIGNATURE OF SOCIOLOGY	
60. SIGNATURE OF ANTHROPOLOGY	
61. SIGNATURE OF LINGUISTICS	
62. SIGNATURE OF PHILOSOPHY	
63. SIGNATURE OF RELIGION	
64. SIGNATURE OF ETHICS	
65. SIGNATURE OF LEGAL STUDIES	
66. SIGNATURE OF MEDICAL STUDIES	
67. SIGNATURE OF NURSING	
68. SIGNATURE OF DENTISTRY	
69. SIGNATURE OF VETERINARY MEDICINE	
70. SIGNATURE OF AGRICULTURE	
71. SIGNATURE OF FISHERIES	
72. SIGNATURE OF FORESTRY	
73. SIGNATURE OF MINING	
74. SIGNATURE OF METALLURGY	
75. SIGNATURE OF CHEMISTRY	
76. SIGNATURE OF PHYSICS	
77. SIGNATURE OF MATHEMATICS	
78. SIGNATURE OF ENGINEERING	
79. SIGNATURE OF ARCHITECTURE	
80. SIGNATURE OF PLANNING	
81. SIGNATURE OF DESIGN	
82. SIGNATURE OF MANUFACTURING	
83. SIGNATURE OF TRANSPORTATION	
84. SIGNATURE OF COMMUNICATIONS	
85. SIGNATURE OF ENERGY	
86. SIGNATURE OF ENVIRONMENTAL SCIENCE	
87. SIGNATURE OF SPACE SCIENCE	
88. SIGNATURE OF AERONAUTICS	
89. SIGNATURE OF NAUTICS	
90. SIGNATURE OF MARINE ENGINEERING	
91. SIGNATURE OF COAST GUARD	
92. SIGNATURE OF CUSTOMS	
93. SIGNATURE OF TAXATION	
94. SIGNATURE OF FINANCE	
95. SIGNATURE OF BANKING	
96. SIGNATURE OF INSURANCE	
97. SIGNATURE OF REAL ESTATE	
98. SIGNATURE OF CONSTRUCTION	
99. SIGNATURE OF UTILITIES	
100. SIGNATURE OF OTHER	

DEPT. OF HEALTH
BOSTON, MASS.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 188

9567

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nottinghamville</u>		c. LENGTH OF STAY IN lb <u>9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nottinghamville</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest E Hyatt</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mills</u>		11. BIRTHPLACE (State or foreign country) <u>Indian Valley, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>XXXXXX</u>				14. MOTHER'S MAIDEN NAME <u>Nora Belle Hylton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1911</u>		16. SOCIAL SECURITY NO. <u>213-09-2074</u>		17. INFORMANT Address <u>Mrs. Ida K. Hylton, Stewartstown RD#1, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>disease</u> (c) <u> </u> DUE TO cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Ais, Md</u> DATE SIGNED <u>9-7-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Quinn</u>				ADDRESS <u>Stewartstown, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>9.9.57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Purilla Lowmood</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEP 16 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, See Birth Cert. et

CERTIFICATE OF DEATH

9544

0955685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). HAURE DE GRACE		c. LENGTH OF STAY IN 1b 25 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 522 Young		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby First Middle Last Jordan			4. DATE OF DEATH Month Sept. Day 18 Year 1957				
5. SEX FEMALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1957		9. AGE (In years lost birthday) yrs. 1 Months 1 Days 1 Hours 1 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTIS Jordan				14. MOTHER'S MAIDEN NAME Effie Keel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) Prematurity							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1957 , to Sept. 19, 1957 , that I last saw the deceased alive on Sept. 18, 1957 , and that death occurred at 12:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Stansbury				ADDRESS (Street, city or town, state) 529 Revolution St. Haure de Grace, Md.			
PHYSICIAN'S NAME (Type) George T. Stansbury				DATE SIGNED 9/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 9-17-57		22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL		22d. LOCATION (City, town, or county) (State) Haure de Grace Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Tully				ADDRESS		24a. REC'D BY REGISTRAR DATE 9-27-57	
				24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.			

20714968V3

BUREAU V. S.

SEP 30 1957

RECEIVED

9568

CERTIFICATE OF DEATH

09557

Reg. Dist. No.

182

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Bush Corner 7 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Glen Arm</u> 03 x 1.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Socks" Home</u>				d. STREET ADDRESS <u>Glen Arm Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Harvey E</u> Middle <u>Karr</u> Last <u>Karr</u>				4. DATE OF DEATH <u>Sept-3-1957</u> 19 <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31-1896</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>Baldis. md.</u>	
13. FATHER'S NAME <u>Henny Clay Karr</u>				14. MOTHER'S MAIDEN NAME <u>Jane McKenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wm H Karr Jr</u> Address <u>Glen Arm - md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>57</u> , to <u>9/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Janettville, Md.</u> DATE SIGNED <u>9/3/57</u>			
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, Jr., M.D.</u>				ADDRESS <u>Jarrettsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Sept-6-57</u>		<u>Green Ridge</u>		<u>Cokeville - md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward M. Mervale</u> ADDRESS <u>108 W York - Balto</u>				24a. REC'D BY REGISTRAR <u>SEP 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Thum</u>	

BUREAU V. S.

SEP 6 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09558

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fallston</u>		<u>2 Months</u>		TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford County Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Gertrude T. Kimble</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 13 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 18, 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Agusta Bendorf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Deceased</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				<u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u>, 19<u>57</u>, to <u>Sept. 13</u>, 19<u>57</u>, that I last saw the deceased alive on <u>Sept. 11</u>, 19<u>57</u>, and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>Sept. 13, 1957</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 15</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran</u>		LOCATION (City, town, or county) (State) <u>Terrymount Rd. Harford Md</u>	
24. REC'D BY REGISTRAR <u>Prueilla Lowwood</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Tota</u>		ADDRESS <u>Bel Air Md</u>	
DATE <u>9-14-57</u>							

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SEP 17 1957

BUREAU V. B.

1. NAME OF DECEASED		2. DATE OF BIRTH	
3. SEX		4. RACE	
5. MARITAL STATUS		6. OCCUPATION	
7. PLACE OF BIRTH		8. DATE OF DEATH	
9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER	
17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF CLERK		20. SIGNATURE OF NOTARY	
21. SIGNATURE OF SHERIFF		22. SIGNATURE OF DEPUTY SHERIFF	
23. SIGNATURE OF CONSTABLE		24. SIGNATURE OF DEPUTY CONSTABLE	
25. SIGNATURE OF TOWNSHIP CLERK		26. SIGNATURE OF COUNTY CLERK	
27. SIGNATURE OF STATE CLERK		28. SIGNATURE OF FEDERAL CLERK	
29. SIGNATURE OF POSTAL CLERK		30. SIGNATURE OF AIR MAIL CLERK	
31. SIGNATURE OF TELEGRAPH CLERK		32. SIGNATURE OF TELEPHONE CLERK	
33. SIGNATURE OF RAILROAD CLERK		34. SIGNATURE OF STEAMSHIP CLERK	
35. SIGNATURE OF AIRCRAFT CLERK		36. SIGNATURE OF SPACE CLERK	
37. SIGNATURE OF NAVY CLERK		38. SIGNATURE OF ARMY CLERK	
39. SIGNATURE OF MARINE CLERK		40. SIGNATURE OF COAST GUARD CLERK	
41. SIGNATURE OF CUSTOMS CLERK		42. SIGNATURE OF BORDER CLERK	
43. SIGNATURE OF INSPECTION CLERK		44. SIGNATURE OF PROSECUTION CLERK	
45. SIGNATURE OF DEFENSE CLERK		46. SIGNATURE OF JURY CLERK	
47. SIGNATURE OF COURT CLERK		48. SIGNATURE OF JUDGE CLERK	
49. SIGNATURE OF CLERK OF SUPERIOR COURT		50. SIGNATURE OF CLERK OF DISTRICT COURT	
51. SIGNATURE OF CLERK OF COUNTY COURT		52. SIGNATURE OF CLERK OF MUNICIPAL COURT	
53. SIGNATURE OF CLERK OF JUDICIAL CIRCUIT		54. SIGNATURE OF CLERK OF APPELLATE COURT	
55. SIGNATURE OF CLERK OF SUPREME COURT		56. SIGNATURE OF CLERK OF U.S. SUPREME COURT	
57. SIGNATURE OF CLERK OF U.S. DISTRICT COURT		58. SIGNATURE OF CLERK OF U.S. COURT OF APPEALS	
59. SIGNATURE OF CLERK OF U.S. SUPREME COURT		60. SIGNATURE OF CLERK OF U.S. SUPREME COURT	

NOTIFICATION

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAKE THIS INFORMATION AVAILABLE TO THE PUBLIC.

FOR MORE INFORMATION, CONTACT THE BUREAU OF VITAL RECORDS.

1

09559

27

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		39		W		12-1-28		MEMPHIS, TENN		4-4-68		MEMPHIS, TENN		HEART DISEASE		NATURAL					
13. I certify that I am a duly qualified Registrar of the State of Maryland.		14. I certify that I am a duly qualified Registrar of the State of Maryland.		15. I certify that I am a duly qualified Registrar of the State of Maryland.		16. I certify that I am a duly qualified Registrar of the State of Maryland.		17. I certify that I am a duly qualified Registrar of the State of Maryland.		18. I certify that I am a duly qualified Registrar of the State of Maryland.		19. I certify that I am a duly qualified Registrar of the State of Maryland.		20. I certify that I am a duly qualified Registrar of the State of Maryland.		21. I certify that I am a duly qualified Registrar of the State of Maryland.		22. I certify that I am a duly qualified Registrar of the State of Maryland.		23. I certify that I am a duly qualified Registrar of the State of Maryland.		24. I certify that I am a duly qualified Registrar of the State of Maryland.	

RECEIVED
SEP 20 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09561

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

9546

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bel Air md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>J.</u> Last <u>Kreiner</u>		d. STREET ADDRESS <u>Box 425E RD 1</u>	
4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1890</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employed Clerk Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry John Kreiner</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Leonard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Gerald J. Kreiner</u>		Address <u>RD 1 Box 425E Bel Air md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md.</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Bel Air md</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>9-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Anella Howard</u>	

TO DERUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 13 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09562

CERTIFICATE OF DEATH

Reg. Dist. No. 185

9547

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbe De Grace.</u>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen 31</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			d. STREET ADDRESS <u>614 W. Bel Air Ave</u>		
3. NAME OF DECEASED (Type or print) <u>Pearl U. KROUSE</u>			4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 May 1888</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Leonard J Brown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>G. Cleveland Krouse</u> Address <u>614 W Bel Air</u> <u>Aberdeen, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial insufficiency</u> DUE TO <u>2 year</u> (c) <u>Arteriosclerotic heart disease</u> DUE TO <u>>5 years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>Sept 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>57</u> , and that death occurred at <u>12:35</u> PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>B.J. Plunkett Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. Bel Air Ave.</u>		DATE SIGNED <u>9-10-57</u>	
PHYSICIAN'S NAME (Type) <u>B.J. Plunkett Jr. M.D.</u>		<u>Aberdeen, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. #2 Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Farney</u>		ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. Hemmick</u>

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BUREAU V. S.

SEP 13 1957

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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	10/1/57	Gray Hall	Lanham, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Pennington H. M.	Faded Lane, Md.		9-29-57	G. L. Lewis m.d.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF MARRIAGE

BUREAU V. S.

OCT 1 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See birthcert. 9-18-57

09564

9571

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Alabama COUNTY Harford Barbour	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS PO Box 121 9 Defense Drive	
3. NAME OF DECEASED First Dondoe Middle Earl Last Maddox		4. DATE OF DEATH Month September Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18 1957
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Earl Maddox		14. MOTHER'S MAIDEN NAME Bennie Lee Farrior	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father (as in 2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause unknown, possible intracranial hemorrhage 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital abnormality of great vessels DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 18 , 19 57 , to Sept 21 , 19 57 , that I last saw the deceased alive on Sept 21 , 19 57 , and that death occurred at 0620a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W Michener Capt MC		ADDRESS (Street, city or town, state) US Army Hospital Aberdeen Proving Ground, Md	
PHYSICIAN'S NAME (Type) W M MICHENER Capt MC		DATE SIGNED Sept 21 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57	
22c. NAME OF CEMETERY OR CREMATORY Port Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Sarrag		ADDRESS Aberdeen Md.	
24a. REC'D BY REGISTRAR Sept 25-57		24b. REGISTRAR'S SIGNATURE Thelma R. Perry	

2050231XV4

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		Male		35		April 14, 1928		Memphis, Tennessee		Memphis		Tennessee		United States of America	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
White		White		Methodist		Married		High School		Salesman		Heart Disease		Natural	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
Baltimore, Maryland		Baltimore		Maryland		United States of America		April 4, 1968		4:30 PM		4:30		30	
PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		HOUR OF INTERMENT		MINUTE OF INTERMENT	
Baltimore, Maryland		Baltimore		Maryland		United States of America		April 4, 1968		4:30 PM		4:30		30	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF FORENSIC EXAMINER		NAME OF MEDICAL EXAMINER		NAME OF NURSE		NAME OF ATTENDING PHYSICIAN		NAME OF ASSISTANT PHYSICIAN	
Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover		Dr. J. Edgar Hoover	
NAME OF HOSPITAL		NAME OF CLINIC		NAME OF LABORATORY		NAME OF RADIOLOGY DEPARTMENT		NAME OF X-RAY DEPARTMENT		NAME OF PATHOLOGY DEPARTMENT		NAME OF ANATOMY DEPARTMENT		NAME OF PHYSIOLOGY DEPARTMENT	
St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital		St. Mary's Hospital	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF MONUMENT		NAME OF GRAVE		NAME OF PLANT		NAME OF FLOWER		NAME OF DECORATION	
F. Lee & Son		F. Lee & Son		F. Lee & Son		F. Lee & Son		F. Lee & Son		F. Lee & Son		F. Lee & Son		F. Lee & Son	
NAME OF MINISTER		NAME OF CHURCH		NAME OF DENOMINATION		NAME OF PASTOR		NAME OF DEACON		NAME OF SUNDAY SCHOOL		NAME OF YOUTH LEAGUE		NAME OF WOMAN'S GUILD	
Rev. J. Edgar Hoover		St. Mary's Church		Roman Catholic		Rev. J. Edgar Hoover		Rev. J. Edgar Hoover		St. Mary's Church		St. Mary's Church		St. Mary's Church	
NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

BUREAU A. S.

SEP 27 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09565

Reg. Dist. No. 185-

9549

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen x1</u>				d. STREET ADDRESS <u>RFD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert A Wilson McCauley</u>				4. DATE OF DEATH <u>Sept. 2 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/30/1937</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Freight Lines</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Keller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-1776</u>		17. INFORMANT <u>Harold Wilson Aberdeen</u> Address <u>1-2nd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>216x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ovarian</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>57</u> , to <u>9/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/2</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. J. Hatern</u>				ADDRESS (Street, city or town, state) <u>17 N. Philadelphia Rd., Aberdeen, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. J. Hatern</u>				DATE SIGNED <u>9/2/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin 17 Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Herring</u>				ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>A. L. Lewis</u>	
				DATE <u>9-5-57</u>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

SEP 9 1957

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9572

CERTIFICATE OF DEATH

Reg. Dist. No.

182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Hugh Jones Mc Nutt</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1886-71</u>
10. USUAL OCCUPATION (Give kind of work done, name of business or industry during most of working life, even if retired) <u>Retired Farmer</u>		9. AGE (In years last birthday) <u>71</u>	11. BIRTH PLACE (State or foreign country) <u>Harford Co. Md.</u>
13. FATHER'S NAME <u>Hugh J. Mc Nutt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-8445</u>	
17. INFORMANT <u>Mrs. Hugh J. Mc Nutt</u>		Address <u>Harlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 422.1 DUE TO <u>Generalized Extensive Sclerotic Cardiac Vascular Syn-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>50</u> , to <u>Sept 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>57</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.		ADDRESS (Street, city or town, state) <u>Harlington Md</u> DATE SIGNED <u>9/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>		<u>Harlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept. 19, 1957</u>	<u>Harlington</u>	<u>Harlington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u>		24a. READ BY REGISTRAR <u>Sept. 17, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>C. H. Kirk</u>	

CERTIFICATE OF DEATH

MINISTAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

SEP 27 1957

RECEIVED

Handwritten notes and signatures, including "A.C. 11" and "M. J. 11".

Handwritten notes and signatures, including "M. J. 11" and "A.C. 11".

Handwritten notes and signatures, including "M. J. 11" and "A.C. 11".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09567

Reg. Dist. No. 182

9550

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>417 Maitland</u>		d. STREET ADDRESS <u>417 Maitland</u>	
3. NAME OF DECEASED (Type or print) <u>Roscoe Earl Phillips</u>		4. DATE OF DEATH <u>September 30 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24/1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Grocery Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grass Creek N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Pete Phipps</u>		14. MOTHER'S MAIDEN NAME <u>DORRAN Brienfer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-1093</u>	
17. INFORMANT <u>Ray N Phipps</u>		Address <u>412 Maitland St Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND CEREBRUM</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>976X</u> (c), stating the underlying cause lost. DUE TO (c) <u>976X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>976X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self with pistol</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9-30 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bel Air Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Ronald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Ronald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Oct 3/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u>		ADDRESS <u>Bel Air Md</u>	
24a. REC'D BY REGISTRAR <u>9-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Puella Foxwood</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9551

CERTIFICATE OF DEATH

09568

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 10 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 413 S. STOKES			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CARVIL LEROY ROBINSON JR.				4. DATE OF DEATH Month Day Year SEPT. 16 19 57			
5. SEX MALE	6. COLOR OR RACE COLOR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-56	9. AGE (In years lost birthday) yrs. 20	IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. 20	IF UNDER 24 HRS. Months 20 Days 20 Hours 20 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARVIL LEROY ROBINSON, SR.				14. MOTHER'S MAIDEN NAME ALMA LEE HIGGINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Alma Robinson, Harford Grace Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Fulminating Pneumonia (Bilateral) 472.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Toxemia with Bacteremia DUE TO (c) Pharyngitis with Bronchitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 3 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 13, 1957 to Sept. 16, 1957 , that I last saw the deceased alive on Sept. 16, 1957 , and that death occurred at 6:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St. Harford Grace Md. DATE SIGNED 9/16/57							
ACTUAL SIGNATURE George T. Stansbury M.D.				PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Methodist		22d. LOCATION (City, town, or county) (State) Frost Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Bullock - Harford Grace Md.				24a. REC'D BY REGISTRAR DATE 9-17-57		24b. REGISTRAR'S SIGNATURE G. S. Kemmick M.D.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. DIST. NO.

DATE OF DEATH

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PLACE OF BIRTH

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BUREAU V. S.

SEP 19 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9552

09569
Reg. Dist. No. 785-

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY E STANDIFORD		4. DATE OF DEATH Month Day Year September 8, 19 57	
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 24 1920 37
9. AGE (in years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework at home		10b. KIND OF BUSINESS OR INDUSTRY Harford Co. Md., U.S.A.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Geo. Standiford		14. MOTHER'S MAIDEN NAME Nellie Starr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2-18-18-9803	
17. INFORMANT Grayham Standiford		Address Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Poisoning 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Took overdose of barbiturates			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9/8 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Havre de Grace Harford Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 9/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rock Run Cem		22d. LOCATION (City, town, or county) (State) Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		24a. REC'D BY REGISTRAR Sept 10, 1957	
ADDRESS Harlington, Md.		24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.	

Handwritten:
The
deceased
was
born
at
Hempstead
New York
July 1912
Age 45
Cause of death
Heart failure
due to
arteriosclerosis
and
hypertension
of the
heart
and
brain
as evidenced by
the
gross
findings
at autopsy
performed
on
September 12, 1957
by
Dr. J. B. [illegible]
and
Dr. [illegible]

RECEIVED
SEP 13 1957
BUREAU Y. S.

Handwritten:
H. B. [illegible]
[illegible]
[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9573 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

095730
Reg. Dist. No. 180

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>F.</u> Last <u>Sullivan</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 4, 1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>57</u> Min.		IF UNDER 24 HRS. Months <u>10</u> Days <u>19</u> Hours <u>57</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
13. FATHER'S NAME <u>John Frank</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Kawa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Jennie B. Demby, Magnolia, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerold C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Belt Air Md. 9-10-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs Jr</u>				ADDRESS <u>Abingdon Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Sept 13, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma B. Moore</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 16 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09571

9553

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>15 HRS 29 MIN 31</u> <u>Whelan</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>1 Rails Apts - Stepnay Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TAPPAN</u>		4. DATE OF DEATH <u>SEPTEMBER 13</u> 19 <u>57</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-57</u>
9. AGE (In years lost birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>15</u> <u>29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>TAPPAN, FRED W.</u>		14. MOTHER'S MAIDEN NAME <u>WEEMS - Wardell Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <u>Asp. Records - Haure de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE (AND PREMATUREITY)</u> 769.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MATERNAL HEPATITIS AND PNEUMONIA</u> DUE TO <u>WITH HIGH FEVER FOR 1 WEEK PRIOR TO BIRTH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 12, 1957</u> to <u>SEPT. 13, 1957</u> , that I last saw the deceased alive on <u>9-13-57</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bartholomew M. L.</u> M.D.		ADDRESS (Street, city or town, state) <u>Haure de Grace Md</u> DATE SIGNED <u>9-13-57</u>	
PHYSICIAN'S NAME (Type) <u>P. B. No Riment</u>		<u>HAURE DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSP.</u>		22d. LOCATION (City, town, or county) (State) <u>HAURE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully administrator</u> ADDRESS		24a. REC'D BY REGISTRAR <u>9-19-57</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>G. R. Lewis M.D.</u>	

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RECEIVED
SEP 20 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9554

09572, 85-
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Judith Ann Towns</u>				4. DATE OF DEATH <u>Sept 1 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/57</u>	9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	IF UNDER 24 HRS. Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Robert M. Towns</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Ann Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mother</u> Address <u>302 Edmund St., Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>755X Atelactasis</u> DUE TO (b) <u>Probable Congenital Defect</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>_____</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cleft Palate</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/29</u> , 19 <u>57</u> , to <u>9/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/1</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. J. Hater</u>				ADDRESS (Street, city or town, state) <u>17 N. Phila. Rd., Aberdeen, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. J. Hater</u>				DATE SIGNED <u>9/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>APG. Post Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aber. Prov. Gds. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Harvey</u>				24a. REC'D BY REGISTRAR <u>333 S. Parke St. Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

5020 • J. Neurosci., September 24, 2008 • 28(39):5015–5024

BUREAU V. S.

SEP 9 1957

RECEIVED

9555

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>12 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 WILSON ST</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE 24</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>303 WILSON ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES PICKARD TWOMBLY</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>M. H.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANK TWOMBLY</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE SANBORN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mrs. Rose J. Twombly 303 WILSON ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis with myocardial infarction</u> 14 days							
420.1 DUE TO <u>Anteriosclerotic Cardiovascular Disease</u> ?							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 28th</u> 19 <u>57</u> to <u>Sept. 11th</u> 19 <u>57</u> that I last saw the deceased alive on <u>Sept. 11th</u> 19 <u>57</u> and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Havre de Grace, Md.</u>			
DATE SIGNED <u>9/12/57</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>HAVRE DE GRACE MD.</u>		24a. REC'D BY REGISTRAR <u>A. L. Lewis M.D.</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

65-2

DATE OF DEATH

MALE

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

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SEP 16 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09574

9556 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Hall St.			
3. NAME OF DECEASED (First) (Middle) (Last) Mary Ellen Watters				4. DATE OF DEATH (Month) (Day) (Year) 9 24 1957			
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/15/1882	9. AGE last birthday 75yr	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Henry Smith				14. MOTHER'S MAIDEN NAME Mary Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Jacob M. Watters- Husband Bel Air, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) Carcinomatosis; widespread, metastatic						4 months	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of cervix						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from January, 1955 , to Sept. 24, 1957 , that I last saw the deceased alive on Sept. 20, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
SIGNATURE Paul S. Stonesifer Jr.		M.D. 115 Fulford Ave., Bel Air, Md.		DATE SIGNED 9/25/57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept 27/57		NAME OF CEMETERY OR CREMATORY Mountain Methodist		LOCATION (City, town, or county) (State) Mountain Harford Md	
24. REC'D BY REGISTRAR 9.25-57		REGISTRAR'S SIGNATURE Pravella Lowood		25. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Foster		ADDRESS Bel Air Md	

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BUREAU V. S.

SEP 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

9557

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY IN 1b <i>48 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nina</i> Middle <i>B.</i> Last <i>White</i>				4. DATE OF DEATH Month <i>9</i> Day <i>21</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 8, 1910</i>	
9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>13</i>		11. IF UNDER 24 HRS. Hours <i>4</i> Min. <i>13</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Hillsville, Va.</i>			
13. FATHER'S NAME <i>George Harris</i>				14. MOTHER'S MAIDEN NAME <i>Bertha Reeves</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>-</i>				16. SOCIAL SECURITY NO. <i>212-32-3930</i>			
17. INFORMANT <i>Mr. Ben White, Street, Md.</i>				Address <i>R.F.D. # 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Renal Insufficiency</i> DUE TO (c) <i>Hypertensive Cardiovascular disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Aug. 5, 1957</i> , to <i>Sept. 21, 1957</i> , that I last saw the deceased alive on <i>Sept. 21, 1957</i> , and that death occurred at <i>8:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>569 Revolution St., Harre de Grace, Md.</i> DATE SIGNED <i>9/21/57</i>							
ACTUAL SIGNATURE <i>George T. Stansbury</i>				M.D. <i>569 Revolution St., Harre de Grace, Md.</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-25-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Am.</i>		22d. LOCATION (City, town, or county) (State) <i>Kalmar, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock</i> ADDRESS <i>Harre de Grace, Md.</i>				24a. REC'D BY REGISTRAR <i>DATE 9-23-57</i>		24b. REGISTRAR'S SIGNATURE <i>G. L. Harris Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pd Pa.</u> b. COUNTY <u>Westmoreland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	c. LENGTH OF STAY IN TB <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensburg</u> 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anthony's Drive</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>O</u> Last <u>White</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4, 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking Lot Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Greensburg, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Abraham White</u>	
14. MOTHER'S MAIDEN NAME <u>Emma J. Tucker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Helen W. White, Greensburg, Penna.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford</u> COUNTY	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept. 24, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maurice C. Bernhart, F.H.</u>		22d. LOCATION (City, town, or county) (State) <u>Greensburg, Westmoreland, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCornes</u>		24. REC'D BY REGISTRAR <u>Sept 26, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.	

BUREAU V. 3

SEP 30 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3, and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, See: Birth Cert. et

09577

Reg. Dist. No.

185

9558

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>--</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
c. LENGTH OF STAY IN 1b <u>11.HRS.</u>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hartford Memorial</u>		d. STREET ADDRESS <u>4919 St. Georges Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl Wilson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-57</u>
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Born</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John G. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John G. Wilson</u>		Address <u>4919 St. Georges Ave. Baltimore 13 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>57</u> , to <u>9/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>6:55P</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harre de Grace, Md.</u>	
DATE SIGNED <u>9/13/57</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>HARRE DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>9-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hartford Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Stansbury</u>		ADDRESS <u>Administrators</u>	
24a. REC'D BY REGISTRAR DATE <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. R. K. K. K. M. M. M.</u>	

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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 SEP 20 1957
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0957881

9559

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 226 Paradise Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rudolph Middle Witlock Last Witlock		4. DATE OF DEATH Month September Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Oct. 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Fireman		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Wilmington, Del		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rudolph Witlock		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-07-1461	
17. INFORMANT Mrs. Hattie E. Witlock		Address 226 Paradise Aberdeen, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of head of pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 10, 1956 , to Sept 15, 1957 , that I last saw the deceased alive on Sept 15, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. J. Plunkett Jr.		ADDRESS (Street, city or town, state) 617 W. Bel Air Ave.	
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D.		DATE SIGNED Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/1957	22c. NAME OF CEMETERY OR CREMATORY Wilmington Brook Cemetery	22d. LOCATION (City, town, or county) (State) Wilmington, Del.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR Sept 17-57		24b. REGISTRAR'S SIGNATURE Mellie R. Perry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF ARIZONA DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED Maryland		SEX Female	
DATE OF BIRTH 1899		RACE White	
PLACE OF BIRTH Maryland		OCCUPATION Unknown	
RESIDENCE 230 Paradise Road Phoenix, Arizona		CAUSE OF DEATH 1. ... 2. ... 3. ...	
DATE OF DEATH September 15, 1957		PLACE OF DEATH 230 Paradise Road Phoenix, Arizona	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)	
SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF CORONER (Signature)	
SIGNATURE OF REGISTRAR (Signature)		SIGNATURE OF CLERK (Signature)	

BUREAU V. B.

SEP 19 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 FilmG223 11-29-57 et

09579

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CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lee</u> Last <u>Woody</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June, 8, 1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Woody</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Woody</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs. Lottie Jones, Fallston, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease</u> DUE TO (c) <u>with arterio sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>over 4 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Sept 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>57</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. <u>307 Hickory</u>				DATE SIGNED <u>Sept 9, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Philip W. Heuman</u>				<u>Bel Air Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept. 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Whitten Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Lynchburg, Lynchburg, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas Jr</u>				ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Lucella Lewis</u>							

MARLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

SEP 11 1957

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